

ovary was left behind, and in others the hæmorrhage was kept up by cicatricial irritation about the stump of the tube or an endometritis. In 94 per cent. of the cases the tumor diminished in size, although menstruation continued in some.

His conclusions are that the operation is contra-indicated for pedunculated, submucous, or subserous tumors, tumors of very large size, or those that have undergone cystic degeneration. For interstitial myomata not reaching above the umbilicus, it is a useful operation and attended with certain results. It should always be carried out if the patient is exhausted from repeated hæmorrhages, or for any other reason she is not able to undergo a long operation. There need be no hesitancy about sacrificing the ovaries, since they are found to be diseased in a large majority of cases.—*Archiv für Gynäkologie*, Band XLVIII, Heft 1.

GEORGE R. WHITE (New York).

**III. Case of Uretero-Cystostomy.** By HOWARD A. KELLY, M.D. (Baltimore). The patient, a woman, had a ureteral fistula in the vault of the vagina, sequel to a vaginal hysterectomy for carcinoma of the uterus. The right ureter was demonstrated to be the one at fault by cystoscopy and sounding of the ureters. Seven weeks after the primary operation the abdomen was opened, and the ureter sought for.

The end of the ureter could not be found on the pelvic floor on account of the rigidity and inflammation surrounding the line of scar tissue between the rectum and bladder. The right ovary and tube were also pinned down to this scar tissue by numerous vascular adhesions. The attempt to reach the ureter at this point was therefore abandoned, and it was sought out at the pelvic brim, where it was readily found after lifting up the caput coli and incising the peritoneum and pushing aside the fat. It was then traced from the point of crossing the common iliac artery down to the pelvic floor, exposing the whole length of the pelvic portion by splitting the peritoneum over its upper surface. The anterior portion of the ureter was involved in the inflammatory material surrounding the scar, which bled

so freely that no attempt was made to dissect it out. Four centimetres of the length of the ureter lying directly posterior to the scar tissue were dissected out, and the ureter lifted up from its bed and divided close to the scar, sacrificing as little as possible of its length.

To secure an easy approximation of the free end of the ureter and the bladder, the bladder was now dissected free from its attachments to the horizontal rami of the pubis on both sides, with scissors and fingers, and dropped down into the pelvis so as to extend it and carry it more into the back part of the pelvis. Then a small incision was made through the bladder wall, covered with fat at least a centimetre thick, at the point on the right nearest the ureteral end drawn straight across the pelvis. This incision passed through the peritoneum, and was not more than three or four millimetres in length, and just large enough to receive the ureter snugly.

The under surface of the ureter was then slit up for about four millimetres, enlarging the calibre of its orifice to avoid a stricture, and with a pair of long, delicate forceps introduced through the urethra, the bladder, and through the incision, the ureteral end was caught and drawn into the bladder and held there while it was being attached to the bladder wall by about six fine interrupted silk sutures passed through the muscular tissue of the bladder and peritoneal and muscular coats of the ureter on all sides, beginning with the under side.

The ureter thus dissected out of its bed and attached to the bladder was stretched like a lax cord from the posterior part of the pelvis to the bladder, which lay gibbous and flattened out on the pelvic floor.

The abdominal incision was closed down to its lower angle, where a narrow gauze drain was inserted for fear of leakage. Care was taken in closing the incision not to draw together the peritoneum underlying its lower end, to avoid raising the bladder and indirectly pulling upon the ureter.

No leakage occurred and the drain was removed, and the

wound healed without suppuration. Her urinary difficulties were immediately and completely relieved with the perfect restoration of continence.—*Johns Hopkins Hospital Bulletin*, February, 1895.

#### BONES, JOINTS—ORTHOPÆDIC.

**I. The Question of Castration as a Factor in the Cure of Osteomalacia.** By Dr. LUDWIG KLEINWÄCHTER. Since 1879, when the operation of castration for osteomalacia was first suggested by Fehling, it has been done forty-one times, as shown by the tables of Fränckel. Many of the cases were improved or cured; some were not improved. The ovaries in this disease showed no characteristic lesion.

The author reports two cases of Cæsarean section in which the ovaries were not removed, but the patients both recovered from the disease. He thinks that in removing ovaries for osteomalacia we are groping in the dark. If the operation is followed by improvement it is accidental. Before undertaking major operations for the cure of osteomalacia, it is necessary to know something of its pathology, which can only be learned by bacteriological and chemical investigations.—*Zeitschrift für Geburtshülfe und Gynäkologie*, Band XXXI, Heft 1.

**II. Treatment of Bone and Joint Tuberculosis.** By Dr. G. NEUBER (Kiel). The author treats tuberculosis of joints and ends of the bones by opening the joint, removing all sequestra and tubercular foci seen, filling the cavity with 10 per cent. iodoform in glycerin, and closing the wound with buried sutures without drainage.

In fourteen cases treated in this way eight healed by primary union, four by granulation without suppuration, and two with slight suppuration.

This method leaves a far better joint than is obtained after resection, and the iodoform and glycerin are claimed to destroy the small amount of tubercular material which may be left behind after the operation.